JAMES D. SHANKS

James Dock Shanks was born November 29, 1833, at Paisley, Renfrewshire, Scotland. He came to Utah in September, 1853, crossing the plains with the Jacob Gates company, and settling in Salt Lake City. About the first job he obtained was helping build the wall around the temple block.

He was married December 21, 1855, to Isabella Muir, daughter of James and Mary Murray Muir, pioneers of 1853. Isabella was born August 15, 1837. Their children were Mary E. (Mrs. Gustave Waldberg), Isabella, James M., William, Marian (Mrs. William Doyle), Elizabeth (Mrs. William Fisher), John M., Margaret (Mrs. McEwan), Archibald (married to Lilly Duke), and George A.

On March 10, 1875, he married Eva Erickson at Salt Lake City. She was the daughter of Eric Erickson and Fredericka Carlson of Upland, Sweden, who came to Utah by railroad. Their children were Catrina Amelia, Joseph, Louise, Josephine, Hyrum, Evelyn and Fredericka.

In 1899 he married Carline Homan at Salt Lake City. She was an immigrant from Germany. They had no family.

Anyone who has the sweet memory of being awakened by the music of the martial band on state occasions and celebrations will remember Jimmy Shanks as the leader and fife player of the group. He also took part in the Blackhawk War and was a member of the Thomas Todd Infantry Company. He was for many years the only tailor in our community.

He built three homes in Heber City. The grounds of each home was landscaped and beautified with flowers and shrubbery. He was really what is called today a "green thumber." He experimented with flowers, trees and shrubs to discover the best suited to our climate.

When stake conference convened at the Stake House and when the Sacrament meeting for Heber was held Sunday afternoons there, it was with pride and pleasure he carried beautiful stately bouquets to place on either side of the pulpit, on the three tiers of the rostrum. These bouquets were made with care and exactness, starting with a row of pansies and building up with flox and sweet william that were interspersed with blades of beautiful ribbon grass. They seemed to fit in with the stately stand and building.

In later years he and his good wife, Carrie, continued taking flowers to beautify the Third Ward chapel that had recently been built and of which he was very proud. He was a sincere Latter-day Saint, a High Priest of this stake, a home missionary and at one time superintendent of the Sunday School at Riverdale.

(MEDICARE NO.) (MEDICAID NO.) (SPONSOR'S SSN) (VA FILE NO.) (SSN) OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

2. PATIENT'S DATE OF BIRTH

3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)

4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NO

5. PATIENT'S SEX
MALE ☐ FEMALE ☐

6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS)

7. PATIENT'S RELATIONSHIP TO INSURED
SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)

☐ INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN

9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)

10. WAS CONDITION RELATED TO:
A. PATIENT'S EMPLOYMENT
YES ☐ NO ☐
B. ACCIDENT
AUTO ☐ OTHER ☐

11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

TELEPHONE NO

11.a. CHAMPUS SPONSOR'S:
STATUS ☐ ACTIVE DUTY ☐ DECEASED ☐ RETIRED
BRANCH OF SERVICE

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING)
I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.

SIGNED DATE

13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW

SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF: ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15. DATE FIRST CONSULTED YOU FOR THIS CONDITION

16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES

16.a. IF EMERGENCY CHECK HERE ☐

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY
FROM THROUGH

DATES OF PARTIAL DISABILITY
FROM THROUGH

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES
ADMITTED DISCHARGED

21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE?
YES ☐ NO ☐ CHARGES:

23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE
1.
2.
3.
4.

B.
EPSDT YES ☐ NO ☐
FAMILY PLANNING YES ☐ NO ☐
PRIOR AUTHORIZATION NO.

24. A DATE OF SERVICE FROM	TO	B * PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN: PROCEDURE CODE (IDENTIFY)	(EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D DIAGNOSIS CODE	E CHARGES	F DAYS OR UNITS	G * TOS	H LEAVE BLANK

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)

26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK)
YES ☐ NO ☐

27. TOTAL CHARGE

28. AMOUNT PAID

29. BALANCE DUE

31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.